Healthcare Group of Arizona

Member Health History Form

www.hcgaz.com • 602.417.6755 • 800.247.2289 (outside Maricopa County)
701 E. Jefferson St. • MD 1400 • Phoenix, AZ 85034

A State-Sponsored Health Plan

COMPLETE ALL SECTIONS OF THIS FORM.
Each enrolling member must complete a separate Health History Form.

HCG USE ONLY
(Classic Benefit Options Only)

Maternity Cap: ❏ Yes ❏ No

Cap Removal Date ______________________

Member ID *(if applicable)* ______________________

Business/Group Name ______________________

HCG Group # ______________________

Member Last Name ______________________ **Member First Name, MI** ______________________

Date of Birth ______________________ **Gender** ______________________

Race or Ethnicity Code *(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.):*

❏ African American ❏ Asian / Pacific Islander ❏ White ❏ American Indian ❏ Hispanic ❏ Other Race or Ethnicity

SECTION A Health Conditions

Please mark **Yes** or **No** if you have received medical advice, diagnosis, care, treatment or taken medication for any of the following conditions in the past six months. Information provided on this form will not affect your premium rates or eligibility. Each member applying must complete a separate Health History Form.

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		101 Allergies; chronic ear, nose or throat problems			114 Blood vessel or circulation disorder; varicose veins; phlebitis			127 Pregnant now? (Due Date):
		102 Cancer? (type and location):			115 Pulmonary embolism or blood clots			128 History of pregnancy complications or miscarriages
		103 Leukemia; CLL			116 Anemia (low blood count)			129 Arthritis; osteoarthritis; rheumatism
		104 HIV/AIDS			117 Hepatitis A, B or C; cirrhosis of liver; jaundice			130 Osteoporosis
		105 Coronary artery disease; cardiovascular disease; heart disease			118 Substance abuse (alcohol or drugs)			131 Rheumatoid arthritis
		106 Stroke or CVA			119 Psychiatric disorder or mental health disorder; depression; ADD, ADHD			132 Lupus; scleroderma
		107 High cholesterol; hyperlipidemia			120 Migraine headache; chronic headaches; cluster headache			133 Trauma or accident to any part of body; broken bone? (which bone and when):
		108 High blood pressure			121 Convulsions or seizures; epilepsy			134 Stomach problems; stomach ulcers; gallbladder stones
		109 Diabetes			122 Multiple Sclerosis			135 Colitis; Crohn's disease
		110 Dialysis; end stage renal disease; chronic renal disease			123 Paralysis; cerebral palsy (CP); polio or muscular dystrophy			136 Eye disorder; cataracts or glaucoma
		111 Kidney disease; kidney stones			124 Asthma			137 Overweight? Height _____ft _____in Weight _____lb
		112 Transplant of organ or tissue? (Type):			125 Chronic lung disease; emphysema; chronic bronchitis; sleep apnea			138 Tobacco use? (Packs per day): Quit? When?
		113 Hemophilia			126 TB			139 Other (list)

If you have consulted with a doctor (MD or DO), physician assistant (PA), nurse practitioner (NP) or therapist in an office, clinic, emergency room, urgent care center or hospital via face-to-face, telephone, correspondence, or any electronic means for medical advice or treatment of any condition within the last six (6) months, please complete all blanks.

Condition # from above	Describe the condition or illness and treatment you received	When did this start? (Mo/Year)	When did you last consult a health provider for this condition?	Are you still receiving treatment? Yes or No	Name, city and telephone number of healthcare provider that you last saw for this condition

Withholding or Falsifying Information is Grounds for Termination of Coverage. **Complete Both Sides/Pages of This Form.**

ENR012–0310–MERCY/UPH-HMO–v2

Member Name ______________________ **Group/Employer Name** ______________________

Member Health History Form

SECTION B Medications, Equipment and Supplies

Please list all of the medicines you are currently taking or that have been prescribed *(if necessary, utilize additional paper):*

Medication	Reason	Dosage & Frequency	Date Prescribed	Prescribing Doctor, City & Phone #	In the last 6 months?	
					Yes	No

To assist with continuity of care, please check mark all of the items (equipment or supplies) you are using now: ❏ Wheelchair ❏ Oxygen ❏ Hospital Bed

Name of company that is supplying equipment ______________________

SECTION C Pre-existing Conditions and Creditable Coverage

Pre-existing Conditions:

- Pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, treatment or medication was recommended or received within six months prior to a member's effective date of coverage under an HCG health benefit package.
- The Healthcare Group program limits coverage for certain pre-existing conditions for 12 months from the effective date of coverage; or, in the case of a "Late Enrollee," 18 months from the effective date of coverage.
- Coverage shall not be provided for covered services related to a pre-existing condition during the pre-existing condition waiting period.
- Pre-existing condition does not include pregnancy, or a genetic condition in the absence of a diagnosis of the condition.

Creditable Coverage and Certificate of Creditable Coverage:

- Creditable coverage is defined in A.R.S. § 36-2912 and includes the process of allowing a credit of one month given for each month of creditable coverage a person had under any qualified health plan network if, after the period of coverage and before the effective date of coverage with HCG, there was not more than 63 consecutive days in which the person was uninsured.
- When determining if pre-existing condition waiting period limitations apply, prior insurance coverage is considered.
- If you have a pre-existing condition and you have not provided a certificate of creditable coverage to Healthcare Group, all claims related to the pre-existing condition may be denied.
- This applies to any prior insurance your or any family members had within the last 18 months.
- No pre-existing condition exclusion waivers or credits will be provided until proof of prior coverage is submitted and approved.
- If you have had insurance coverage in the past 18 months, attach a copy of the Certificate of Creditable Coverage to your enrollment form.

SECTION D Coordination of Benefits

If you answer Yes to any of the following questions, additional information may be requested.

1. Have you ever suffered from an illness or disability as a result of Employment? ❏ No ❏ Yes
2. Have you ever suffered from an illness or disability as a result of Military Service? ❏ No ❏ Yes
3. Are you currently receiving any type of disability insurance benefits? ❏ No ❏ Yes Payor ______________________
4. Are you eligible for treatment at a VA hospital? ❏ No ❏ Yes

SECTION E Current/Prior Health Coverage

You may have other healthcare coverage or Healthcare Group coverage. If you currently have, or recently terminated other health insurance, please provide the following information. **Also, please provide certificate(s) of creditable coverage**.

Type of Coverage: ❏ Group ❏ Individual ❏ Medicaid (AHCCCS) ❏ Medicare* ❏ Other: ______________________

Health Plan Name ______________________ **Health Plan Address** ______________________

Health Plan Phone # ______________________ **Will Healthcare Group coverage replace this coverage?** ❏ No ❏ Yes

Group/Policy # ______________________ **Coverage Eff. Date** ______________ **Coverage End Date** ______________

***Medicare Card #** (if applicable) ______________________ **Eff. Date** __________ ❏ Part A ❏ Part B ❏ Part D ❏ Advantage

SECTION F Disclosure Statement and Signature

DISCLOSURE STATEMENT: I certify that the information provided on this form is complete and true to the best of my knowledge and is the basis of my enrollment in Healthcare Group. Furthermore, I understand that:

- Any visit or consultation in any form with a medical provider at which testing, diagnosis, treatment, or recommendation for treatment for any condition or disease is made between the date on this form and the effective date of coverage must be reported in writing to HCG. If the supplemented information is not reported to HCG, the Member's coverage may be rescinded and the Member will owe the costs of any services paid;
- Any misrepresentation or omission, whether intentional or unintentional, regarding the presence of a pre-existing condition will result in cancellation of my medical coverage;
- I will be responsible for any costs incurred for non-covered services and services that exceed benefit limit or dollar amount listed in my benefit plan while under the plan.

I further understand that any costs associated with providing such information or records will be at my expense and not the expense of Healthcare Group or my Health Plan.

Signature of Person Completing Form ______________________ **Relationship** ______________ **Date** ______________